



# Board of Hearing Care Providers

121 South Fruit Street, CONCORD, NH 03301  
Tel. (603) 271-9482 Fax (603) 271-6702  
TDD Access: Relay NH 1-800-735-2964

## SUPERVISED PRACTICE PLAN FOR AUDIOLOGISTS

### TO BE COMPLETED BY APPLICANT

#### General Information

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Business(\_\_\_\_) \_\_\_\_\_ Home(\_\_\_\_) \_\_\_\_\_

#### Training Program Responsibilities

Diagnostics \_\_\_\_\_

Aural Rehabilitation \_\_\_\_\_

Identification and Evaluation of Hearing Impairment \_\_\_\_\_

Record Keeping \_\_\_\_\_

Staff Meetings \_\_\_\_\_

In-Service Training \_\_\_\_\_

#### Employment Information

Employer \_\_\_\_\_  
(company name) (division or department)

Address \_\_\_\_\_  
\_\_\_\_\_

Beginning date of employment \_\_\_\_\_  
Date Supervised Training Program to start \_\_\_\_\_  
Date Supervised Program to end \_\_\_\_\_  
Average number of hours per week \_\_\_\_\_

**TO BE COMPLETED BY SUPERVISOR**

Name: \_\_\_\_\_  
(last) (first) (middle initial)

Address: \_\_\_\_\_  
\_\_\_\_\_  
(city) (state) (zip code)

Telephone Business: (\_\_\_\_) \_\_\_\_\_ Home(\_\_\_\_) \_\_\_\_\_

Registration# \_\_\_\_\_

**This Plan Must Be Completed, Signed, And Returned To The Board Office Within Thirty (30) Calendar Days Of The Start Of Your Supervised Training Program.**

METHODS	SESSIONS/MONTH	LENGTH/SESSION	ACTIVITY
On-site observations			
Remote observations (audio, videotape)			
Conference (phone)			
Review of Records 1. Therapy plans 2. Diagnostic reports			
Staff Meetings			
Case Staffing (placement meetings)			

### **Recommendation of Supervisor**

1. Has the applicant fulfilled professional employment responsibilities? Yes No  
If no, please describe:

\_\_\_\_\_

\_\_\_\_\_

I hereby (    ) recommend (    ) do not recommend

\_\_\_\_\_ for licensure in the area of audiology.  
(applicant's name)

\_\_\_\_\_ (signature of supervisor) \_\_\_\_\_ (date)